VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 3, 2015

Ms. Mary Belanger, Manger
St Joseph's Residential Care Home
243 North Prospect Street
Burlington, VT 05401-1609

Dear Ms. Belanger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 27, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

PRINTED: 11/12/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0155	A. BUILDING: _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S RESIDENTIAL CARE HOME	243 NORTH PROSPECT STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was completed by the Division of Licensing and Protection on 10/27/15; the survey was a follow up to a survey of 8/26/15. The following deficiency was found.	R100		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that all residents administered medications had written signed orders for 1 of 5 applicable residents in the survey. (Resident #5). Findings include: Per record review, Resident #5 was admitted to the home on 8/25/15 and there were no admission orders for medications and treatments signed by the physician as of the date of survey, 10/27/15. The resident was receiving 2 routine daily medications and a treatment to the foot without signed orders in the medical record. Per interview with the nurse, the physician failed to provide written orders although s/he had been contacted by telephone on 3 occasions. The only medication order that had been signed by the physician was a telephone order for warfarin.	R162	To guard against admitting residents with incomplete physicians orders, the attached form must be completed by the nurse doing the admission and countersigned by the DNS prior to admission. If any of the information is missing, the admission will not occur until the documentation is complete. This form will be kept as part of the admission paperwork. Please see attached form "Pre-admission Checklist." R162 POC accepted MBolton RN/PMC 12/3/15	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administration 11/24/15

PRE-ADMSSION CHECKLIST

The following forms need to be completed or copies provided PRIOR to admission.

Resident name:_____

Admission date:_____

INSURANCE CARDS-copies of front and back of all insurance cards

COMPLETE AND SIGNED PHSYCIANS ORDERS: Yes _____ Initials _____

EMERGENCY CONTACT INFORMATION: Yes _____ Initials _____

RESIDENT PICTURE- 2 COPIES: Yes_____ Initials _____

COLST: Yes _____ Initials _____

ADVANCED DIRECTIVES: Yes _____ No _____

MEDICAL RELEASE OF INFORMATION FORM: Yes _____ Initials _____

LEVEL III ADMISSION APPROVAL SIGNED BY PHYSICIAN: Yes _____ Initials _____

PRN STANDING MEDICATION ORDERS: Yes _____ Initials _____

COMPLETED DIAGNOSIS LISTING: Yes _____ Initials _____

IF INFORMATION IS NOT COMPLETED BY 10:00AM ON DATE OF ADMISSION, ADMISSION WILL BE POSTPONED UNTIL ALL DOCUMENTATION IS COMPLETE.

Signature of nurse completing admission:_____ Date: _____

Signature of DNS:_____Date: _____